EXHIBIT A

Show

BlueCross BlueShield of Tennessee Medical Policy Manual

Proton Beam Therapy

DESCRIPTION

Proton beam therapy is a type of particulate radiation therapy that differs from conventional electromagnetic and/or photon radiation therapy. The use of protons is produced by an accelerator (cyclotron, synchrotron, synchrocyclotron, or linear). This type of radiation is proposed to allow for minimal scattering as particulate beams pass through tissue disposing ionizing energy at precise depths (i.e., the Bragg peak) to minimize tissue damage in the surrounding area.

Please note: For this specific policy, pediatric age is defined as age 21 and younger.

POLICY

- Proton beam therapy is considered ***medically necessary*** if the medical appropriateness criteria are met. **(See Medical Appropriateness below.)**
- Proton beam therapy for the treatment of all other conditions/diseases, including, but not limited to, the following is considered ***investigational*** unless there are unique clinical circumstances applicable to a specific member that would make use of proton beam therapy medically appropriate:
    - Anal canal cancer
    - Bladder cancer
    - Breast cancer
    - Cervical and endometrial cancer
    - CNS cancer, primary (other than pediatric malignancies)
    - Esophageal cancer
    - Gastric Cancer
    - Head and neck cancer (other than those listed as medically appropriate)
    - Hodgkin's Lymphoma
    - Malignancies requiring craniospinal irradiation (other than pediatric malignancies)
    - Non-Hodgkin's Lymphoma
    - Non-small cell lung cancer (NSCLC) at any stage or for recurrence
    - Pancreatic cancer
    - Prostate cancer
    - Rectal cancer
    - Retroperitoneal sarcoma
    - Sarcoma
    - Seminoma
    - Thymomas and thymic carcinoma

MEDICAL APPROPRIATENESS

- Proton beam therapy is considered **medically appropriate** if **ANY ONE** of the following criteria are met:
    - Primary therapy for uveal melanoma when considered preferential to brachytherapy
    - Postoperatively for the treatment of localized chordoma or chondrosarcoma of the base of the skull or cervical spine
    - Maxillary sinus or paranasal/ethmoid sinus cancer/tumors
    - Localized unresectable hepatocellular carcinoma or intrahepatic cholangiocarcinoma when sparing normal tissue cannot be adequately achieved with photon-based radiotherapy.
    - Treatment of pediatric malignancies

IMPORTANT REMINDERS

- Any specific products referenced in this policy are just examples and are intended for illustrative purposes only. It is not intended to be a recommendation of one product over another and is not intended to represent a complete listing of all products available. These examples are contained in the parenthetical e.g. statement.
- We develop Medical Policies to provide guidance to Members and Providers. This Medical Policy relates only to the services or supplies described in it. The existence of a Medical Policy is not an authorization, certification, explanation of benefits or a contract for the service (or supply) that is referenced in the Medical Policy. For a determination of the benefits that a Member is entitled to receive under his or her health plan, the Member's health plan must be reviewed. If there is a conflict between the Medical Policy and a health plan or government program (e.g., TennCare), the express terms of the health plan or government program will govern.

ADDITIONAL INFORMATION

For the treatment of localized prostate cancer, as well as other listed conditions considered investigational, proton beam therapy has not been shown to be superior to conventional radiation therapy at this time. Further randomized controlled studies are needed.

SOURCES

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MOST RECENT REVIEW DATE: 8/1/2023

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